20 August 2006
Statement of [redacted] LCDR, USCG
Engineer Officer, USCGC Healy

The following is a statement of facts as best as I recollect them in regards to my actions and observations of the events surrounding deaths of LT Hill and BM2 Duque on 17 August 2006.

I was in my stateroom having returned from the ice about 30 minutes earlier, when I heard the pipe that there was some sort of problem at the bow. When I arrived at the scene, I witnessed CPR being administered on two people. I thought three people had gone diving but I didn't see the third. Neither victim appeared to be conscious or responding in any way.

Two litters had arrived on scene just ahead of me and everyone started working to move the victims into the litters. The straps of the litters didn't get opened up properly in the excitement but the sense of urgency dictated the need to get them aboard the ship as quickly and carefully as possible without wasting any more time fumbling with strapping them in properly. I agreed with this sense of urgency and personally helped carry BM2 Duque aboard.

There was some initial confusion among those of us carrying BM2 Duque at the top of the 02 deck ladder as to whether to take him to the hyperbaric chamber or to sickbay. I didn't know what all of his injuries were, I saw that he was not breathing, was unconscious, had an embolism, & I suspected hypothermia. I knew that the urgency to get him breathing was the most critical need over any others, so I ordered them to take him to sickbay.

In sickbay, HSC [redacted] and LTjg (Doc) [redacted] took over control of the situation and LT Hill was brought in right behind us. CPR was re-started on both victims and continued by various people over the course of the next hour or so, all of whom I knew to be more qualified than myself at CPR and they were under the direction of HSC & Doc the whole time.

Someone brought the hyperbaric chamber into sickbay, so EMCM [redacted] and I started trying to figure out how to put it together. I had never even seen a hyperbaric chamber that was not a big steel pressure cylinder so was quite surprised at the inflatable chamber in front of me. EMCM [redacted] seemed just as new to it as I was, but together we started piecing together the puzzle. ENS [redacted] tried to help, MK2 [redacted] and MK1 [redacted] and several others helped gather parts, pieces, tools, O2 bottles, SCUBA tanks, regulators, hoses, O-rings, fittings, and a multitude of other items as Master Chief [redacted], Ens [redacted], and I put this thing together. Once assembled, I believe it was MK1 [redacted] volunteered to go inside and check the sound system and air mask. Following these checks, we decided to pressure check the chamber with no one inside of it. It tested SAT. We deflated and opened it back up and reported it ready for use to Doc, and we all got out of the way, and out of sick bay. I sensed there would be no need for the chamber.

In the struggle to put the chamber together, I felt that the instructions were very vague and confusing, but one thing I remember being clearly stated was that the chamber should only be assembled and used by personnel who were trained and familiar with the chamber. None of us were qualified for that, but we did the best that we could under these circumstances. Clearly written simple instructions would have enabled us to complete assembly much quicker.

Following the announcement of their death, I assisted in carrying the bodies to the Climate Control Chamber, and directed my engineering watch to maintain the temperature between 35-37degF per Doc's instructions. I also directed the engineering watch to make hourly rounds to check and log the temperature in the Machinery Log.

Following the placement of the bodies in the reefer, I helped clean up the various effected spaces.

This concludes my direct involvement [redacted] accident and concludes my statement. This is a true and complete accounting of events as [redacted] them.

[redacted]

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